COLORADO MEDICAID
GLOBAL PRIOR AUTHORIZATION FORM

61343

Request Date ___ / ___ / ____

PATIENT INFORMATION

Patient's Medicaid ID Number

Patient's Date of Birth ___ / ___ / ____

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: ___ - ___ - ____

Prescriber Fax: ___ - ___ - ____

Prescriber NPI #

Prescriber DEA # __ - _____

For Global PA approval client must meet all of the following criteria:

1. **( ) Check if you are the client's focal point of care provider**

2. **Check one of the following boxes to indicate that this client is at high risk for drug-drug interactions:**
   ( ) Patient is taking four or more medications OR
   ( ) Patient is taking high risk medications requiring specific patient education, close monitoring, or special personnel for administration.
   List high risk medication(s): _____

3. **Check one of the following boxes to indicate the client's diagnosis:**
   ( ) HIV/AIDS - taking antiretroviral therapy.
   ( ) Severe chronic schizophrenia and severe bipolar disorder- diagnosis based on DSM-IV criteria and ICD-9 diagnosis codes.
   ( ) Traumatic Brain Injury - An injury caused by a blow or jolt to the head, penetration of the head, or violent shaking, that disrupts the function of the brain, resulting in long-term or lifelong need for help in performing activities of daily living.
   ( ) Developmental disability - Manifested before age 22 and attributable to mental retardation*, cerebral palsy, epilepsy, or autism. Diagnosis includes: life-long disability, inability to live independently, severe communication difficulties and/or profound intellectual disability.

**** As defined by the American Association of Intellectual and Developmental Disabilities***

Date ___ / ___ / ____

Signature of Prescriber _____

By signature, I confirm that I will act as the client's focal point of care provider, the information above is accurate and verifiable in patient records and that I will prescribe preferred agents whenever clinically appropriate.

61343

FAX TO: COLORADO Medicaid Prior Authorizations
Fax: (888)-772-9696
PA HELPDESK: (800) 365 - 4944